

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13604

13601

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 290

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TA/bot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 6 hr. 5 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS GRASONVILLE 1780.2	
3. NAME OF DECEASED (Type or print) Saul Thomas		First Saul	Middle Thomas
4. DATE OF DEATH Month 12 Day 20 Year 1957	5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1939	9. AGE (In years at birthday) 18 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) oyster shucker	10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Saul Thomas Adams	14. MOTHER'S MAIDEN NAME Elizabeth Benson	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.			
17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause first. DUE TO (c) + fract. injury -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Harry Fashot	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)	DATE SIGNED 12/20/57		
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORIAL Greenwood Cemetery	22d. LOCATION (City, town, or county) Princess Anne, Md (State)
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons	ADDRESS Criefield, Md	24e. REC'D. BY REGISTRAR DATE 12/23/57	24f. REGISTRAR'S SIGNATURE N. H. Neeris

RECEIVED  
BUREAU V.

EC 97 - 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be revoiced by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached from use as the burial permit. Then please remove carbon papers. Pages 1 & 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13602

## CERTIFICATE OF DEATH

13605  
Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>		c. LENGTH OF STAY IN 1b <i>11 days.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>		
3. NAME OF DECEASED (Type or print) <i>R</i>		First <i>Carl</i>	Middle <i>Bamberger</i>	
4. DATE OF DEATH <i>December 23 1957</i>	Month <i>December</i>	Day <i>23</i>	Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 8, 1895</i>	
9. AGE (in years last birthday) <i>62 yrs.</i>	10. IF UNDER 1 YEAR Months <i>1</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Reinhardt F. Bamberger</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>Delaware</i></i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Reinhardt F. Bamberger</i>	14. MOTHER'S MAIDEN NAME <i>Margaret A. Biddle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>1</i>	16. SOCIAL SECURITY NO. <i>1</i>	17. INFORMANT <i>Miss Mabel Mc Creas (friend)</i>	Address <i>219 S. Westrington St. 2400-57</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i>				
INTERVAL BETWEEN ONSET AND DEATH <i>443X</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Hypertension</i> (c) <i>Heart disease</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month <i>19</i>	Day <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>219 S. Westrington St. 2400-57</i>
21. I certify that I attended the deceased from <i>1957</i> to <i>1957</i> , that I last saw the deceased alive on <i>1957</i> , and that death occurred at <i>1957</i> M, from the causes and on the date stated above. ADDRESS (Street, city, or town, state) <i>219 S. Westrington St. 2400-57</i>				
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>	DATE SIGNED <i>12/27/57</i>			
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>	M.D. <i>219 S. Westrington St. 2400-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-27-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Wilmington Cem.</i>	22d. LOCATION (City, town, or county) <i>Wilmington, Dela.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Norman D. Marshall - St. Michael</i>	ADDRESS <i>12/27/57</i>	24a. REC'D BY REGISTRAR <i>12/27/57</i>	24b. REGISTRAR'S SIGNATURE <i>W.H. Murray</i>	

BY PROXY OF THE ATTACHED ATTACHMENT  
RECEIVED IN THE COURT OF APPEAL

BUREAU V. S

DEC 01 1987

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13606

13603

## CERTIFICATE OF DEATH

Reg. Dist. No. 890

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>28 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton - Rural</i>		d. STREET ADDRESS <i>05x22</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>DENISE</i>	Middle <i>ANNE</i>	Last <i>BEULAH</i>	4. DATE OF DEATH <i>12</i>	Month <i>12</i>	Day <i>12</i>	Year <i>1957</i>	
5. SEX <i>f</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/29/57</i>	9. AGE (in years last birthday) <i>7 mo.</i>	10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>73</i>	12. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>James Austin Beulah</i>		14. MOTHER'S MAIDEN NAME <i>Viola Downes</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>James Austin Beulah</i>		Address <i>—</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7544 Congenital Heart Disease, Patent Inter. atrial septal Defect</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at 7:50 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		M.D.		ADDRESS (Street, city or town, state) <i>219 S. Washington St 13 Dec 57</i>		DATE SIGNED <i>13 Dec 57</i>		
PHYSICIAN'S NAME (TYPE) <i>Old Schmidt</i>		EASTON, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/4/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul's</i>		22d. LOCATION (City, town, or county) <i>near Federalsburg Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. Frampton &amp; Son, Federalsburg, Maryland</i>		ADDRESS <i>2030202 XV4</i>		24a. REC'D BY REGISTRAR <i>12/4/57</i>		24b. REGISTRAR'S SIGNATURE <i>M.H. Heirin</i>		

## CERTIFICATE OF DEATH

BUREAU X-2

DEC 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13624

## CERTIFICATE OF DEATH

13697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		d. STREET ADDRESS Box 189	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 189						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Henrietta	Middle Pauline	Last Brooks	4. DATE OF DEATH 12	Month 8	Day 19	Year 57
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/09	9. AGE (in years lost birthday) 48 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Freeman		14. MOTHER'S MAIDEN NAME Lottie Gibson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 513-24-1194		17. INFORMANT Preston Brooks, Trappe, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		CEREBRAL VASCULAR ACCIDENT				INTERVAL BETWEEN ONSET AND DEATH 2 m.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Easton	(County) (State) Wicomico Md.
21. I certify that I attended the deceased from 12-8-1957 to 12-8-1957 that I last saw the deceased alive on 12-8-1957, and that death occurred at 4:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Donald F. Bartley</i> M.D. ADDRESS (Street, city or town, state) 9 N. Union St. DATE SIGNED 12-10-57 PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D. Easton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/57	22c. NAME OF CEMETERY OR CREMATORIAL Williamsburg Cem.	22d. LOCATION (City, town, or county) Easton, RT. 1	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell	ADDRESS Easton Md.	24a. REC'D BY REGISTRAR DATE 12-19-57	24b. REGISTRAR'S SIGNATURE <i>Mr. J. H. Young</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE  
CERTIFICATE OF DATA

BUREAU V. S.

DEC 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13625

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

136018  
290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newcomb</i>		b. COUNTY <i>Talbot</i>	
c. LENGTH OF STAY IN 1b <i>25 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newcomb</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>On Home</i>		d. STREET ADDRESS <i>—</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Harley</i>	First <i>C.</i>	Middle <i>Burgess</i>	Last <i>December 24 1957</i>
4. DATE OF DEATH Month <i>December</i>	Day <i>24</i>	Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21 1905</i>
9. AGE (In years last birthday) <i>52 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>6</i>	Days <i>3</i>	Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>	
10c. BIRTHPLACE (State or foreign country) <i>Springport, Mich</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Earl C. Burgess</i>		14. MOTHER'S MARRIED NAME <i>Ophelia Craft Burgess</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>180-14-0693</i>	
17. INFORMANT <i>Mrs Hazel Burgess Newcomb, Md</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the under- lying cause (c). <i>—</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiac infarction</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>8:56 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. Paul Whittle</i> PHYSICIAN'S NAME (Type) <i>John D. Williams</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 27, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Easton, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John D. Williams, Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>12/27/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. R. Nease</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director,  
Page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with  
the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

基于对称的二元树模型，通过将树的左右子树对称地映射到一个共享的树上，从而实现对称的二元树模型。

SUREAU V. S.

DEC 31 1957

RECEIVED

of high pressure gas system and  
will return with the 2nd

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13805

## 13626 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>		c. LENGTH OF STAY IN 1b <b>4 Hrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Talbot</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whittman</b>		f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First	Middle	Last	4. DATE OF DEATH <b>13 12 57</b>	Month	Day	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-13-13</b>	9. AGE (In years lost birthday) <b>44 yr</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kidderman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oysterman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Howard Burton</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Adams</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>212-09-8994</b>			
17. INFORMANT <b>Hilton Burton, Whittman, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> )					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO <b>Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <b>atherosclerotic coronary heart</b>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Whittman, com</b>					
20f. (City or town) <b>Whittman, Md.</b>		(County)		(State)					
21. I certify that I attended the deceased from <b>1-20</b> , 19 <b>57</b> , to <b>12-28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-28-57</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Whittman, Md.</b>									
DATE SIGNED <b>1-2-58</b>									
ACTUAL SIGNATURE <b>Howard Burton</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>Howard Burton</b>									
22a. FUNERAL CREMATION: REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-1-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Whittman com</b>		22d. LOCATION (City, town, or county) <b>Whittman, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Marshall, Easton, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>James B. Marshall, Easton, Md.</b>			
VS A15 (4) ISM 9/55				DATE <b>JAN 1 1958</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4  
may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ETUADU V. S.

JAN 13 1971

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13611				
Item 11. Revision 1-7-57										Reg. Dist. No. 290				
13604 CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY		Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)		b. STATE		MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Easton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x St. Michaels		d. STREET ADDRESS		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, <u>87</u> months, <u>87</u> days)	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>
		W			1880	Months	Days	Min.	M	W	<input checked="" type="checkbox"/>	1880	87	87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
						Maryland		USA						
13. FATHER'S NAME		George Edmonds		14. MOTHER'S M AIDEN NAME		Julia Frazier		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		
								Yes				Mrs Mary Fisher - Daughter		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH						
		47		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last!				30 days						
		(b)		DUE TO		Atherosclerotic Cardio-Vascular; 5 years								
		(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Urinary		44 x				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
19														
21. I certify that I attended the deceased from 11/25/57 to 12/24/57, that I last saw the deceased alive on 11/24/57, and that death occurred at 1:45 p. m. from the causes and on the date stated above.								ADDRESS (Street, city or town, state)		DATE SIGNED 12/26/57				
ACTUAL SIGNATURE		Phane Wirth		M.D.		St. Michaels, Md								
PHYSICIAN'S NAME (Type)		R. LANE, M.D.		St. Michaels, Md										
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		12/26/57		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)				
								Clint Cemetery		St. Michaels, Md				
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
								12/26/57		12/26/57				

BUREAU V. S.

JAN 3 1989

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13613

13605

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>		c. LENGTH OF STAY IN 1b <i>5 1/2 hrs.</i>		b. COUNTY <i>Caroline</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Ollie C. Fluharty</i>		First	Middle	Last	4. DATE OF DEATH <i>December 13 1957</i>	Month	Day	Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 27 1886</i>	9. AGE (In years last birthday) <i>71</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during past 6 months working life, even if retired) <i>Poaled Lassoo</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Textile</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Charles C Fluharty</i>		14. MOTHER'S MAIDEN NAME <i>Susan Turner</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>41-11111-111-00</i>		17. INFORMANT <i>Mr. William K. Fluharty (brother)</i>		Address <i>Clinton Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerosis, Generalized</i>		DUE TO (b) <i>Arteriosclerosis, Generalized</i> DUE TO (c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton</i>		20f. (City or town) <i>Easton</i>	(County) <i>Caroline</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>1957</i> , to <i>12/13/1957</i> , that I last saw the deceased alive on <i>12/13/1957</i> , and that death occurred at <i>10:40 AM</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>Easton Md</i>		DATE SIGNED <i>12/13/1957</i>						
ACTUAL SIGNATURE <i>Jay Cox</i>		M.D.						
PHYSICIAN NAME (Type) <i>P E Cox MD</i>		22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						
22b. DATE THEREOF <i>12/15/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Friendship</i>		22d. LOCATION (City, town, or county) <i>near Federalsburg</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Tracy, Easton, Federalsburg, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>12/15/57</i>				
				24b. REGISTRAR'S SIGNATURE <i>N. L. Nease</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 1977

Undertaker says man's name is,  
Charles Oliver Fleekarty



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13606

## CERTIFICATE OF DEATH

Reg. Dist. No.

13615  
240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ridgely</i>		d. STREET ADDRESS <i>05x02</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Walter</i>	Middle <i></i>	Last <i>Gurnage</i>	4. DATE OF DEATH <i>December 29 1957</i>	Month <i>December</i>	Day <i>29</i>	Year <i>1957</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 2 1886</i>	9. AGE (in years last birthday) <i>71 yrs</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dove</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>Ben Gurnage</i>		14. MOTHER'S MOTHER'S NAME <i>Martha Teat</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Trusty Gurnage (brother)</i>		Address <i></i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>465X</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		DUE TO (b) <i>Alimentary embolus</i>						
		DUE TO (c) <i>Port of B.C.H.</i>						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>12/14/57</i> to <i>12/29/57</i> , that I last saw the deceased alive on <i>12/29/57</i> , and that death occurred at <i>6:20 AM</i> , from the causes and on the date stated above								
ADDRESS (Street, city or town, state) <i></i>								
ACTUAL SIGNATURE <i>P. E. Cox</i>								
PHYSICIAN'S NAME (Type) <i>P. E. Cox</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/2/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Easton</i>		22d. LOCATION (City, town or county) (State) <i>Easton, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boelens</i>		ADDRESS <i>Greensboro, Md.</i>		24a. REC'D. BY REGISTRAR DATE <i>1/3/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. H. Neives</i>		

BUREAU V. 1

May 3 1968

REGISTRÉ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13627

## CERTIFICATE OF DEATH

13616

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death Page 4  
 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3's may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Talbot</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bozman</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bozman</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bozman</b>	
d. STREET ADDRESS <b>Bozman</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>CATHERINE</b>		First <b>C</b> Middle <b>A</b> Last <b>NELIA HARDCASTLE</b>	
4 DATE OF DEATH <b>December 12, 1957</b>		Month	Day
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1939</b>
9. AGE (In years from birthday) <b>18 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Easton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>E. Lockwood Hardcastle, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Edmund</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>E. L. Hardcastle, Jr., Bozman, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 min</i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first  (b) DUE TO  <i>Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
(c)  <i>Mucoviscidosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 28, 1957</b> to <b>Dec 12, 1957</b> that I last saw the deceased alive on <b>Dec 12, 1957</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>St. Michaels, Md.</b> DATE SIGNED <b>12-13-57</b>	
ACTUAL SIGNATURE <i>R. Lane Whorrell</i>		PHYSICIAN'S NAME (Type) <b>M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 14, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hamblton Harrison, St. Michaels</i>		ADDRESS <b>St. Michaels, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 16 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Deb. S. L.</i>	

1000 V. 2

10

1000 V. 2

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13607 CERTIFICATE OF DEATH

13617

Reg. Dist. No. 90

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. STREET ADDRESS Centerville Road, EASTON	
3. NAME OF DECEASED (Type or print) First Eleanor		4. DATE OF DEATH Month 12 Day 4 Year 1957	
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8-1893
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles E. Lomax	
14. MOTHER'S MAIDEN NAME Lida Scwell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Fred S. Harrison, husband - Centerville Road, EASTON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Casualty by her son		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1957, to <u>4 Dec</u> , 1957, that I last saw the deceased alive on <u>4 Dec</u> , 1957, and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. DATE SIGNED PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u> <u>4 Dec 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Sherwood Cemetery		22d. LOCATION (City, town, or county) Sherwood Md	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thurston Harrison, St. Michaels MD</u>		24a. REC'D BY REGISTRAR DATE 12/7/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>M. L. Neere</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 2000

2



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13618

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg</i>		d. STREET ADDRESS <i>E. Central Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Gertrude</i>	Middle <i></i>	Last <i>Harting</i>	4. DATE OF DEATH <i>Dec 10 1957</i>	Month <i>Dec</i>	Day <i>10</i>	Year <i>1957</i>		
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 28, 1898</i>	9. AGE (In years last birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>	13. IF UNDER 24 HRS Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurant Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Rosemont, Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Edward J. Harting</i>		14. MOTHER'S MAIDEN NAME <i>Mabel F. Guiseil</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>824-34-7337</i>			17. INFORMANT <i>Spouse, Husband, Wife</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Hemorrhagic peritonitis</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i></i>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Dec 10, 1957</i>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20d. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from alive on <i>Dec 10, 1957</i> , to <i>Dec 10, 1957</i> , that I last saw the deceased and that death occurred at <i>10:15 A.M.</i> from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <i>2195 Westinghouse St, 100057</i>		23. ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>		24. DATE SIGNED <i>13/12/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>13/12/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Washington Cemetery</i>		22d. LOCATION (City, town, or county) <i>St. Michaels, Md.</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barney Miller</i>		24. ADDRESS <i>Federalsburg, Md.</i>		24d. REG'D BY REGISTRAR <i>13/12/57</i>		24e. REGISTRAR'S SIGNATURE <i>M. H. Neerius</i>			

U. S.

50

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13609

## CERTIFICATE OF DEATH

Reg. Dist. No. 13609

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Greenbriar</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbriar 11x</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hosp -</i>		d. STREET ADDRESS <i>Kent Narrows</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	first <i>Warren</i>	Middle <i> </i>	Last <i>Hutton</i>	4. DATE OF DEATH	Month <i>December</i>	Day <i>20</i>	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <i>42 yrs.</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work week, even if retired) <i>Oyster Shucker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i> </i>	
13. FATHER'S NAME <i> </i>		14. MOTHER'S MAIDEN NAME <i>Elsie King</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i> </i>		16. SOCIAL SECURITY NO		17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>44.52</i>		DUE TO <i> </i>		Central Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO <i> </i>		Anticoagulant - Hypertension			
		DUE TO <i> </i>		Cardio - Vascular Disease		? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
Hour o. p. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>57</i> , to <i>Dec 20</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Dec 20, 1957</i> , and that death occurred at <i>6 Gillett</i> , M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Greenbriar, Md.</i>		DATE SIGNED <i>12/20/57</i>	
ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>	M.D.						
PHYSICIAN'S NAME (Type) <i>Irvin G. Hoyt M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-26-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Auburn Cem</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. A. Jackson Funeral Home</i>		ADDRESS <i>916 Parsons Ave.</i>	24a. REC'D BY REGISTRAR <i>12/26/57</i>	24b. REGISTRAR'S SIGNATURE <i>W. A. Neesley</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1-2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

EC 97 1957

DESEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "PENDING" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the registrar or to burial or removal.

Item 5 '57-21 File MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13619

13610 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY	TALBOT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL)	Rural Easton		c. LENGTH OF STAY IN 1b		d. STATE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Memorial Hospital		d. COUNTY	
d. STREET ADDRESS		Rural Denton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
PERCY	O		HYNES	Oct. 26, 1882	75 yrs	28	1957
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH	8. WIDOWED <input type="checkbox"/> DIVORCED	9. AGE (in years and birthday)			
M	W			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm owner	Farming	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S M AIDEN NAME		
Henry W. Hynes	Audie Gibson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Esper Florence Hynes	Denton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO	
816X Fat Embolism secondary to Fracture of Left Hip	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.	(b)
	DUE TO
	(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Passenger in auto in auto-auto collision	

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street offce bldg., etc.)	20f. (City or town)	(County)	(State)
5	12/27/57		Street	Easton	Talbot	Md.

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>
---

ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)
Funeral	Dec 31, 1957	Denton	Denton	Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
J. Virgil Moore, Son	Denton	12/31/57	N. H. Nease	

1876-1

BERG C. MATHIS

15 28 25

BUREAU U. S.

X

AN 3 10

RECEIVED  
15-5-5

1876-1  
BERG C. MATHIS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13621

13611

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>15 hrs. 45 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michael's</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Sarah</i>	Middle <i>L</i>	Last <i>Jackson</i>	4. DATE OF DEATH <i>12 28 1957</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>August 5 1870</i>	8. AGE (In years last birthday) <i>87 yrs</i>	9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mr Noah Jackson</i>		14. MOTHER'S MARRIED NAME <i>Anna Cummings</i>		Address <i>McLydia Cottman (Niece) St. Michael's</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>McLydia Cottman (Niece) St. Michael's</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>anemia</i> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>arteriosclerotic cardiac &amp; Renal.</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>260X</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>260X</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>St. Michael's</i>		(County) <i>St. Michael's</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Sept 1957</i> to <i>Dec 28 1957</i> , that I last saw the deceased alive on <i>Dec 28 1957</i> , and that death occurred at <i>5:15 A.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>St. Michael's Md.</i>		DATE SIGNED <i>12-30-57</i>			
ACTUAL SIGNATURE <i>Guy M. Reeser</i>		PHYSICIAN'S NAME (Type) <i>Guy M. Reeser</i>		M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Dec 30/57</i>		22b. DATE THEREOF <i>Dec 30/57</i>		22c. NAME OF CEMETERY OR CREMATORIY <i>St. Michael's Md.</i>		22d. LOCATION (City, town, or county) <i>St. Michael's Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Woman B Marshall</i>		ADDRESS <i>St. Michael's</i>		24e. REC'D BY REGISTRAR DATE <i>1/31/57</i>		24d. REGISTRAR'S SIGNATURE <i>M. A. Neary</i>	

BUREAU V.

M 3 175

1002

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13612

## CERTIFICATE OF DEATH

13622

Reg. Dist. No. 290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Delaware</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bridgeville</u>	
c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS Box 164	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Albert</u>	Middle <u>E</u>	Last <u>James</u>
4. DATE OF DEATH	Month <u>12</u>	Day <u>27</u>	Year <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 27 1894</u>
9. AGE (In years last birthday) <u>63</u> yr		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during past 6 months, even if retired) <u>U.S. Bookshop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Next myself</u>	
10c. BIRTHPLACE (State or foreign country) <u>England</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
12. FATHER'S NAME <u>Joseph P. James</u>		14. MOTHER'S MARRIED NAME <u>Emma BAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no. or unknown) <u>Yes</u> <input type="checkbox"/> <u>Give rank and date of service</u> <u>Private #1</u>		16. SOCIAL SECURITY NO. <u>Mr. Madge James Bridgwater Del</u>	
17. INFORMANT <u>Mr. Madge James Bridgwater Del</u>		Address <u>119 S Washington St, Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Employment</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Employment</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <u>Employment</u>			
DUE TO (c) <u>Employment</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Easton</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 S Washington St, Easton, Md.</u>			
ACTUAL SIGNATURE <u>E.C. H. Schmidt</u>		DATE SIGNED <u>28 Dec 57</u>	
PHYSICIAN'S NAME (Type) <u>E.C. H. Schmidt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 31, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.C. H. Schmidt</u>		24a. REC'D BY REGISTRAR <u>Paul Oliver</u> DATE <u>12/31/57</u>	
ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Nease</u>	

BUREAU V. E.  
BUREAU V. E.

IAN 3 1969

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13623

13613

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>145 P. 1 Pox 51</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth Elaine Kellyn</u>		First	Middle	Last	4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1957</u>
5. SEX <u>F</u>		6. COLOR OR RACE <u>Neigh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4/1/31</u>	9. AGE (In years last birthday) <u>30 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lived at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Floyd Holland</u>		14. MOTHER'S MAIDEN NAME <u>Mary Benable</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Floyd Holland</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <u>Carcinoma of Stomach</u> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO <u>Metastatic to ovary</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9 a.m.</u> 19 <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/16/57</u> to <u>19</u> , that I last saw the deceased alive on <u>12/16/57</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>F.C.H. Schaeffer</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington St 3 Dec 57</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Old John</u>		M.D. <u>Easton</u> md.			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/57</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Richards Cem.</u>	
22d. LOCATION (City, town, or county) <u>Easton</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Dornmill</u>		ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>12/6/57</u> DATE <u>12/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>M.A. Neerier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-death permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S' A D' Z M

A faint, horizontal, handwritten mark or signature, possibly the letter 'C', is located at the top center of the page. It is very light and appears to be a scan of a physical document.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Log #1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13628

## CERTIFICATE OF DEATH

13624

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY  Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) b. STATE  Maryland		b. COUNTY  Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Easton		c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <sup>1</sup> Rural Easton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Day	Year
EDWARD HALTIMAN		EDWARD	HALTIMAN	KLEPPINGER	Dec. 21,	19 57	
5. SEX Males	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1905	9. AGE (in years 52 lost birthday) yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY DelMarVa Narrow Ribbon Factory		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME G. Byron Kleppinger		14. MOTHER'S MAIDEN NAME Elizabeth B. Haltzman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, No, or Unknown)		16. SOCIAL SECURITY NO. 180-10-8683		17. INFORMANT Mrs. E. H. Kleppinger		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 10 minutes initial diff 1953	
(b) Arterosclerotic cardiovascular disease		DUE TO					
(c) Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Talbot Md.	
21. I certify that I attended the deceased from 12/21, 1957, to 12/26, 1957, that I last saw the deceased alive on 12/21, 1957, and that death occurred at 8:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Ludwig J. Egger</i> M.D. 12 N. Hanson St. EASTON, MD. PHYSICIAN'S NAME (Type) <i>LUDWIG J. EGGER</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery		22d. LOCATION (City, town, or county) Macungie, Pennsylvania (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE 12/24/57		24b. REGISTRAR'S SIGNATURE <i>N.H. Neelies</i>	

20 VI. 8

DEC

155

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13614 CERTIFICATE OF DEATH

13625

Reg. Dist. No. 270

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE				
Fellst		MARYLAND New York				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		b. COUNTY				
c. LENGTH OF STAY IN 16 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 65 Central Park West				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type of name) W. Thomas		First	Middle			
		Dimock	Leonard			
4. DATE OF DEATH		Month	Day			
		12	4			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George D. Leonard		14. MOTHER'S MAIDEN NAME Elizabeth Bernock				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT My husband N. Leonard (son) Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Chronic congestive heart —		INTERVAL BETWEEN ONSET AND DEATH 6 w		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Cirrhosis of liver, heart disease		192		
(c)						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gastro-intestinal bleeding, came suddenly				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) E. (County)		(State)
19				20f. (City or town) Easton, Maryland		
21. I certify that I attended the deceased from 11/22/57 to 12/4/57, that I last saw the deceased alive on 12/4/57, and that death occurred at 3:31 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) E. (County)		DATE SIGNED 4 Dec 57		
ACTUAL SIGNATURE H. Harrison		M.D.				
PHYSICIAN'S NAME (Type) H. Harrison						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 9, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Oakwood Cemetery		22d. LOCATION (City, town, or county) Baltimore
						(State)
23. FUNERAL DIRECTOR'S SIGNATURE A. Harrison		ADDRESS Easton, Maryland		24a. REC'D. BY REGISTRAR Date 12/3/57		24b. REGISTRAR'S SIGNATURE M. Harrison

3407-2

350

350

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13806

## 13615 CERTIFICATE OF DEATH

Reg. Dist. No 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 15 mins.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural 09X1	
3. NAME OF DECEASED (Type or print) First Patricia Middle Ann Last Macer		4. DATE OF DEATH December 28 1957	
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1957	
9. AGE (In years last birthday) yrs 9		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 9 Days 11 Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Cambridge, Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Perry		14. MOTHER'S M AIDEN NAME Dora Macer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT None Ida Macer, Rhodesdale, Md., R.F.D. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493 X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-28-1957 to 12-28-1957 that I last saw the deceased alive on 12-28-1957, and that death occurred at 12:15 PM, from the causes and on the date stated above ACTUAL SIGNATURE Donald F. Bartley M.D. ADDRESS (Street, city or town, state) 9 N Hanson St. DATE SIGNED 1-9-58 PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D. Easton, Md.			
22a. BURIAL CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Rhodesdale Cemetery		22d. LOCATION (City, town or county) (State) Rhodesdale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 11/11/57	
24b. REGISTRAR'S SIGNATURE Mrs. J. J. Frampton			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

2067161XV4

BRUNA V. S

IAN 13 1993

DEPARTMENT OF  
EDUCATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13626

13629

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1 PLACE OF DEATH a. COUNTY <b>Talbot</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trappe</b>		c. LENGTH OF STAY IN lb <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Green's Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>JESSE</b>		First <b>JESSE</b>	Middle <b>MARDEN</b>
4. DATE OF DEATH <b>Dec. 30,</b>		Month <b>Dec.</b>	Day <b>30</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>Dec. 8, 1874</b>		9. AGE (in years less birthday) <b>83 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rug &amp; Carpet Sales</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13. FATHER'S NAME <b>Jesse Marden</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Maria Brice</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO <b>Spanish-Amer. 214-22-0743</b>		17. INFORMANT <b>Mrs. Jesse Marden</b>	Address <b>Trappe, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (b) DUE TO  (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>1</b> p.m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that I attended the deceased from <b>12-30-</b> , 19 <b>57</b> , to <b>12-30-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-30-</b> , 19 <b>57</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>97 N. Hanover St.</b>		DATE SIGNED <b>12-31-57</b>	
ACTUAL SIGNATURE: <b>Jesse M. Marden</b>		M.D.	
NAME (Type) <b>J</b>		NAME (Type) <b>Easton, Md.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Jan. 1, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Easton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>12/31/57</b>
			24b. REGISTRAR'S SIGNATURE <b>M. E. Newnam</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUKEAU V. L.

AN 3 1963

REVIEW

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13616 CERTIFICATE OF DEATH

Reg. Dist. No. 13621  
10

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg EASTON</b>		c. LENGTH OF STAY IN 1b 1 week		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>QUEEN ANNE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRASONVILLE</b>		d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MR. TILGHMAN</b>	First <b>JAMES</b>	Middle <b>MELVIN</b>	Last <b>MELVIN</b>	4. DATE OF DEATH 12 21 19 57	Month Year	Day	Year		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <b>May 22, 1892</b>	10. AGE (In years last birthday) <b>65 yrs</b>	11. IF UNDER 1 YEAR Months <b>1</b>	12. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRACKMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(RETIRED) RAILROAD</b>		10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>SAMOEL MELVIN</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE GOODHAM</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown No)		16. SOCIAL SECURITY NO <b>77-07-9662</b>		17. INFORMANT <b>5/22/57 Ac. 12. 31. 1957</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cerebral a. of heart.		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown		(County)	(State)
21. I certify that I attended the deceased from <b>19 Dec</b> , 1957, to <b>21 Dec</b> , 1957, that I last saw the deceased alive on <b>21 Dec</b> , 1957, and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Harrison</i>		ADDRESS (Street, city or town, state) <b>Chestertown, Maryland</b>		DATE SIGNED <b>23 Dec 1957</b>					
PHYSICIAN'S NAME (Type) <b>HARSTON HARRISON</b>		M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-24-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Chesapeake Cemetery</b>		22d. LOCATION (City, town, or county) <b>Centerville, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harston Harrison</b>		ADDRESS <b>1001 N. Batson St., Chestertown, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 2/24/57</b>		24b. REGISTRAR'S SIGNATURE <b>M. H. Morris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be given to you as the burial-trust permit. Then please remove carbon paper. Pages 1 & 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

DEC 27 1965

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13628

290

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE b. COUNTY	
13617 Baltimore Maryland		Maryland Caroline	
c. LENGTH OF STAY IN 1b Easton		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) TRENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS o.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Delphia	Middle Ellen	Last Merritt
4. DATE OF DEATH	Month Dec	Day 20	Year 1957
5. SEX f	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1887
9. AGE (in years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		
10c. BIRTHPLACE (State or foreign country) W. Virginia			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Alfred Propst		14. MOTHER'S MASTERN NAME Julia McCarty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT M. Blair Merritt (son)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 29 hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b)			
DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/19</u> , 1957, to <u>12/20</u> , 1957, that I last saw the deceased alive on <u>12/20</u> , 1957, and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Harrison		M.D.	
PHYSICIAN'S NAME (Type) THURSTON HARRISON MD		Postage Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/57	22c. NAME OF CEMETERY OR CREMATORIAL J. G. Crem. Cem. Winchester	22d. LOCATION (City, town, or county) Md
23. FUNERAL DIRECTOR'S SIGNATURE J. Harrison Son	ADDRESS Federalburg	24a. REC'D BY REGISTRAR DATE 12/23/57	24b. REGISTRAR'S SIGNATURE M. H. Nease

RECEIVED  
BUREAU

DEC 27 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13630 CERTIFICATE OF DEATH

Reg. Dist. No. 13629

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman		b. COUNTY Talbot	
c. LENGTH OF STAY IN 1b 60 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Sedgewick		First Middle Murphy	4. DATE OF DEATH 12 2 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oysters	9. AGE (In years last birthday) 60 yrs
		11. BIRTHPLACE (State or foreign country) Tilghman, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Murphy		14. MOTHER'S M AIDEN NAME Anna Cummings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-32-6902	17. INFORMANT Mrs. Emily Murphy - Tilghman, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 480.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		coronary occlusion	
DUE TO (b) Coronary artery disease		5 yrs	
DUE TO (c) Arteria sclerosis		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. <i>Aug 1957</i> 1957 p.m. <i>12:55</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from olive on <i>Nov 20</i> 1957, and that death occurred at <i>12:55 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Tilghman, Md. 2031903</i>	
ACTUAL SIGNATURE <i>George M. Reeser Sr.</i>		DATE SIGNED <i>12-1-57</i>	
PHYSICIAN'S NAME (Type) <i>George M. Reeser Sr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-1-57	22c. NAME OF CEMETERY OR CREMATORIAL Tilghman Methodist	22d. LOCATION (City, town, or county) (State) Tilghman Talbot Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>George M. Reeser Sr.</i>	ADDRESS Tilghman, Md.	24a. REC'D BY REGISTRAR DATE <i>Dec 5 1957</i>	24b. REGISTRAR'S SIGNATURE <i>George M. Reeser Sr.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

E. J. V. S.

15

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13631

## 13618 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Salisbury</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>40 da.</i>		a. STATE <i>Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. STREET ADDRESS <i>McDaniel</i>		b. COUNTY <i>Salisbury</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First	Middle	Last	4. DATE OF DEATH <i>Palmer</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>B</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 29 1858</i>	9. AGE (in years last birthday) <i>99 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>George Palmer</i>		14. MOTHER'S MAIDEN NAME <i>Charity Davis</i>		Address <i>Catherine Palmer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4200</i>		DUE TO <i>Cardiac failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>Atherosclerosis, general</i>		2. (c) <i>A. H. D.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/21</i> , 1957, to <i>10/1</i> , 1957, that I last saw the deceased alive on <i>10/1</i> , 1957, and that death occurred at <i>6:10 PM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>H. F. Kinnaman M.D.</i>		ADDRESS (Street, city or town, state) <i>Easton, Md.</i>		DATE SIGN'D <i>12/12/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-4-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Bozman Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Bozman, Md.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Darby</i>		ADDRESS <i>Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>12/13/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>M. J. Neerue</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the bus or transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU 11. 9

227

DEC

LEADER

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13632

## 13631 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		d. STREET ADDRESS <i>Tilghman</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>CHARLES</i>		First <i>S.</i>	Middle <i>Phillips</i>
4. DATE OF DEATH <i>DEC 20 1957</i>		5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>JULY 6, 1886</i>		8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years lost birthday) <i>71 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WATERMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SEAFOOD</i>	10c. BIRTHPLACE (State or foreign country) <i>Tilghman, MD</i>
11. CITIZEN OF WHAT COUNTRY? <i>USA</i>		12. MOTHER'S MAIDEN NAME <i>GERTRUDE Hood</i>	
13. FATHER'S NAME <i>CHARLES F. Phillips</i>		14. MOTHER'S MAIDEN NAME <i>GERTRUDE Hood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO <i>213-10-2394</i>	17. INFORMANT <i>BENJAMIN F. Phillips, Tilghman, MD</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) coronary atherosclerosis (c) atherosclerosis of heart</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>✓</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Tilghman</i>
20f. (City or town) <i>Tilghman</i>		(County) <i>Calvert</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Sept 20, 1957</i> to <i>Dec 20, 1957</i> , that I last saw the deceased alive on <i>Dec 20, 1957</i> , and that death occurred at <i>Tilghman</i> , M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Tilghman, Calvert, Md.</i> DATE SIGNED <i>Dec 20, 1957</i>			
ACTUAL SIGNATURE <i>GUY M REESE SR</i>			
PHYSICIAN'S NAME (Type) <i>GUY M REESE SR</i>			
22a. FUNERAL CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 23, 1957</i>	
22c. NAME OF CEMETERY OR Crematory <i>Methodist Cemetery</i>		22d. LOCATION (City, town, or county) <i>Tilghman</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Hamilton Harrison, St. Michaels</i>		24a. ADDRESS <i>St. Michaels</i>	
24b. REC'D BY REGISTRAR <i>Dec 23, 1957</i>		24c. REGISTRAR'S SIGNATURE <i>John C. Smith</i>	
VS A15 (4) 15M 9/55			

REF ID: A112020

1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13619

## CERTIFICATE OF DEATH

13633

Reg. Dist. No. 270

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>New Hampshire</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kesten</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Boston, N.H. 204</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp Washington St.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Florence E. Rebenkahn</i>		4. DATE OF DEATH <i>December 31 1957</i>	5. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 18, 1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>New York</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Agnew Walsh</i>	
14. MOTHER'S MAIDEN NAME <i>Florence Conover</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no. or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Rudolph W. Rebenkahn</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>532X</i>		DUE TO <i>Linical throat disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>	
21. I certify that I attended the deceased from <i>19 Dec</i> , 1957, to <i>21 Dec</i> , 1957, that I last saw the deceased alive on <i>21 Dec</i> , 1957, and that death occurred at <i>11:45 AM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Thurston Harrison</i>	M.D.	ADDRESS (Street, city or town, state) <i>Bethesda, Maryland</i>	DATE SIGNED <i>21 Dec 57</i>
PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>			
22a. BURIAL/CREMATION REMOVAL (Check) <i>Dec 23, 57</i>	22b. DATE THEREOF <i>Dec 23, 57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Rockwood Cemetery</i>	22d. LOCATION (City, town, or county) <i>Bethesda, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. C. of B. &amp; H.</i>	ADDRESS <i>1000 2nd</i>	24a. REC'D BY REGISTRAR DATE <i>2/23/57</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Morris</i>

BUREAU V. S

DEC 07 1977

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13620

## CERTIFICATE OF DEATH

13631

Reg. Dist. No. 290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be reformed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the birth/death permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <i>Maryland</i>		If institution Residence before admission b. COUNTY <i>Caroline</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9th 20 ins</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg</i>		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Donald A. Robinson</i>		First	Middle	Last	4. DATE OF DEATH <i>December 13 1957</i>	Month	Day	Year		
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. B. DATE OF BIRTH <i>November 3 1957</i>	9. AGE (In years last birthday) yrs <i>1 74</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>1</i>	Day <i>74</i>	Hours <i>0</i>	Min <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>				
13. FATHER'S NAME <i>Donald R. Aldrich</i>		14. MOTHER'S MAIDEN NAME <i>Doris Ann Robinson</i>				Address <i>2011 Robinson (now) Federalsburg Md</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>None</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gasoline - In</i>	INTERVAL BETWEEN ONSET AND DEATH	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) <i></i>		(b)  DUE TO <i></i>						(c)  DUE TO <i></i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>19</i>	Day <i>10</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9:30 P.M., from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <i>219 S. Washington St. 14 Dec 37</i>	DATE SIGNED
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		M.D.								
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		Easter 16, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/16/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cobdenbury</i>		22d. LOCATION (City, town, or county) <i>Near Federalsburg Md</i>		(State) <i></i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. O. ... 1. &amp; Federalsburg Md</i>		ADDRESS <i>Franktown 3 Son</i>		24a. REC'D BY REGISTRAR <i>12/16/57</i>		24b. REGISTRAR'S SIGNATURE <i>W.H. Nelson</i>				

## Introduction

186 EC

7. 2000-19

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13635

Reg. Dist. No. 0-70

13635

## CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Rural</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>25 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Delia</i>		First <i>Delia</i>	Middle <i>Rebecca</i>
4. DATE OF DEATH <i>Dec. 9- 1957</i>		5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 26-1890</i>	
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter's wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		9. AGE (In years lost birthday) Yrs. <i>67</i> Months <i>7</i> Days <i>14</i> Hours <i>0</i> Min <i>0</i>	
13. FATHER'S NAME <i>William James Hopkins</i>		14. MOTHER'S MAIDEN NAME <i>Elinor B. Hopkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>214-36-72548</i>	
17. INFORMANT <i>Daughter</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Focal septocephalomyelitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <i>Sept. 1957</i> , 19 <i>57</i> , to <i>Dec. 12, 1957</i> , 19 <i>57</i> , that I last saw the deceased and that death occurred at <i>219 S. West St., Baltimore, Md.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>219 S. West St., Baltimore, Md.</i>		DATE SIGNED <i>Dec. 12, 1957</i>	
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>		PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 12, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Easton, Rural Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Williams, Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Dec. 12, 1957</i>	
ADDRESS <i>John J. Williams, Easton, Md.</i>		24b. REGISTRAR'S SIGNATURE DATE <i>Dec. 12, 1957</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

URBAN V. S

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9755

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13621

## CERTIFICATE OF DEATH

13636

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		b. COUNTY <b>Caroline</b>	
c. LENGTH OF STAY IN 1b <b>3 days.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		d. STREET ADDRESS <b>R.F.D #2</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Paul</b>	Middle <b>Vernon</b>	Last <b>Sharp</b>
4. DATE OF DEATH	Month <b>12</b>	Day <b>11</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 11, 1917</b>
9. AGE (In years last birthday) yrs <b>40</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	13. FATHER'S NAME <b>John Sharp</b>		
14. MOTHER'S MARRIED NAME <b>Anna Stewart</b>	Address <b>Louise Sharp wife - same</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) If yes, give war or date of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteria</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>(b) Chronic glomerulonephritis</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. 31.</b> <b>p. m.</b>	20d. INJURY OCCURRED While <b>Not while</b> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Denton</b> (County) <b>Md.</b> (State)
21. I certify that I attended the deceased from <b>11/11/57</b> , 1957, to <b>11/14/57</b> , 1957, that I last saw the deceased alive on <b>11/11/57</b> , 1957, and that death occurred at <b>11/14/57</b> , 1957, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Denton</b> DATE SIGNED <b>12 Dec 57</b>			
ACTUAL SIGNATURE <b>Wm. H. James</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 14</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Denton</b>		22d. LOCATION (City, town, or county) <b>Denton</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. James &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>10/13/57</b>	
ADDRESS <b>Denton</b>		24b. REGISTRAR'S SIGNATURE <b>N. A. Neeris</b>	

БУНДАУ В. 2

200 - 0

РЕГИСТРАЦИЯ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13633

## CERTIFICATE OF DEATH

13639  
290

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician and completely filled in by the funeral director.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>TALBOT</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TRAPPE</i>		c. LENGTH OF STAY IN 1b <i>10</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		d. STREET ADDRESS <i>14 TREO AVN AVE</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mrs. Grimm's Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JAMES BENNETT Todd</i>		First	Middle	Last	4. DATE OF DEATH <i>DEC. 6 1957</i>	Month	Day	Year	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>AUG. 8, 1863</i>	9. AGE (In years lost birthday) <i>94 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER - RET.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARMING</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>WILLIAM EDWARD Todd</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET TESTER</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Douglas Todd</i>		Address <i>14 TREO AVN AVE, EASTON, MARYLAND</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Arterio Sclerosis</i>		DUE TO (b) <i>Serility</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o m p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <i>At home</i>		20f. (City or town) <i>Easton</i>		(County) <i>Wicomico Co.</i>	(State) <i>MARYLAND</i>
21. I certify that I attended the deceased from <i>March 18, 1957</i> to <i>Apr. 24, 1957</i> , that I last saw the deceased alive on <i>April 24, 1957</i> , and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>Gratze, Md.</i>	
ACTUAL SIGNATURE <i>William S. Seymour</i>								DATE SIGNED <i>1957</i>	
NAME (Type) <i>William S. Seymour</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/9/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>HILLCREST CEMETERY</i>		22d. LOCATION (City, town or county) <i>FEDERALSBURG, MARYLAND</i>		(State) <i>MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Kingston Powell</i>		ADDRESS <i>EASTON, MD.</i>		24a. REC'D BY REGISTRAR <i>12/9/57</i>		24b. REGISTRAR'S SIGNATURE <i>N. H. Neerier</i>			

LENAUD V. S.

1000

LENAUD

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 13622 CERTIFICATE OF DEATH

13640

Reg. Dist. No.

290

## 1. PLACE OF DEATH

a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Easton

c. LENGTH OF STAY, IN 1b

21 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Memorial Hospital

3. NAME OF DECEASED  
(Type or print)

First Middle

Helen V

Last

Tracey

## 4. DATE OF DEATH

December 6

Year

1957

## 5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

July 3 1896

## 9. AGE (In years, months, days)

61 yrs

## 10. IF UNDER 1 YEAR

Months Days

## 11. IF UNDER 24 HRS

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

N.W.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

45A

## 13. FATHER'S NAME

George Whacker

## 14. MOTHER'S MAIDEN NAME

Ella Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

McClay L. Tracy (husb)

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

175X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.(b)  
DUE TO  
(c)INTERVAL BETWEEN  
ONSET AND DEATH

Cervicalgia of ovary

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, and that death occurred at \_\_\_\_\_, from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

M.D.

219 S Washington St. 920057

PHYSICIAN'S  
NAME (Type)

E.C.H. Schmidt

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

25. DATE

12/9/57

N.H. Morris

СИМУ В. С.

150

ДЕГЕНЕРЕН

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13642

13631

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		11. 2. USUAL RESIDENCE (Where deceased lived) a. STATE <i>Maryland</i>		b. INSTITUTION b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Cordova</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Cordova</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>LOUIS</i>	Middle <i>EDGAR WHITBY</i>	Last	4. DATE OF DEATH	Month <i>DEC</i>	Day <i>8</i>	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 17, 1876</i>	9. AGE (In years last birthday) <i>81</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired). <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Whithby</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cheeseman</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Euro Edgar Whithby Cordova, Jr.</i>		Address <i>Cordova, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last  (b)  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Cerebral Sclerosis & Heart Disease Cerebral sclerosis Generalized.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Talbot</i>	(County) <i>Maryland</i>
21. I certify that I attended the deceased from <i>June 8, 1957</i> to <i>Aug 8, 1957</i> that I last saw the deceased alive on <i>June 8, 1957</i> and that death occurred at <i>Talbot</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Ridgeley, Maryland</i> DATE SIGNED <i>Charles H. Winnacott M.D.</i>							
ACTUAL SIGNATURE <i>Charles H. Winnacott</i>		PHYSICIAN'S NAME (Type) <i>CHARLES H. WINNACOTT</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 11, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Greenwood</i>		22d. LOCATION (City, town, or county) <i>Talbot</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Angel Moore-Bar Paton</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>12/4/57</i>		24b. REGISTRAR'S SIGNATURE <i>M.A. Neeris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTRY V. S.

DEC 11 1964

REGISTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director,  
 page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13635

## CERTIFICATE OF DEATH

Reg. Dist. No.

13643  
270

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellevue Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Addison Wilson</u>		First <u>William</u>	Middle <u>Addison</u>
Last <u>Wilson</u>		4. DATE OF DEATH <u>Dec 18</u>	Month <u>18</u> Year <u>1957</u>
S. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 9 1896</u>
9. AGE (In years lost, birthday) <u>61</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. KIND OF BUSINESS OR INDUSTRY <u>Salesman</u>	12. BIRTHPLACE (State or foreign country) <u>Easton, Md.</u>
13. FATHER'S NAME <u>William Addison Wilson</u>	14. MOTHER'S M AIDEN NAME <u>Alice Elizabeth Adams</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>	
16. SOCIAL SECURITY NO. <u>World War I 23-07-9560</u>	17. INFORMANT <u>Mrs. John G. Watson, Queenstown, Md.</u>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>322.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>7</u> o. m. p. m. <u>12-18</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) <u>Easton</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, Note) <u>Easton Md</u>			
ACTUAL SIGNATURE <u>Lewis Meltz DME M.D.</u>	DATE SIGNED <u>12-20-57</u>		
PHYSICIAN'S NAME (Type) <u>INEATV</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 23, 57</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Melhine, Easton, Md.</u>	ADDRESS <u>John D. Melhine, Easton, Md.</u>	24a. REG'D BY REGISTRAR DATE <u>12/23/57</u>	24b. REGISTRAR'S SIGNATURE <u>J. H. Neives</u>

HTA20 30 HTA-2013-12 2013-12

100

卷之三

10

卷之三

260 *Journal of Health Politics, Policy and Law*

12 3121 9-2000

W. H. 1883

John Morris

## ANSWER

وَمَنْ يَعْمَلْ مِثْقَالَ ذَرْنَةٍ

## Answers

## W - 2 - 5

Digitized by srujanika@gmail.com

3166 3740

Matthew

1917-18 125

## 3. *Chlorophytum* (L.) Willd.

DOKEAO V. 3

DEC 27 1957

RECEIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13644

Reg. Dist. No. 290

## CERTIFICATE OF DEATH

13623

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. Washington St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HO Easton	
3. NAME OF DECEASED (Type or print) Emma Cole Wilson		d. STREET ADDRESS S. Washington St.	
4. DATE OF DEATH December 30 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Operator-Ret. Telephone		9. AGE (In years at birthday) 73 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Felix Wilson	
14. MOTHER'S MAIDEN NAME Florence Cole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Minerva Freeland, <sup>address</sup> S. Washington St, Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Atherosclerotic heart disease (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>Dec.</u> , 1957, that I last saw the deceased alive on <u>Dec. 30</u> , 1957, and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 9 N. Benson St. DATE SIGNED 12-30-57.	
ACTUAL SIGNATURE Donald F. Bartley M.D.		PHYSICIAN'S NAME (Type) Donald F. Bartley Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/58	22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. Farnham Currie		24e. REC'D BY REGISTRAR JAN 2 1958 REGISTRAR'S SIGNATURE D. J. H. Morris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1958

REGELY ED